Oncology Clinical Pathways
Bladder Cancer

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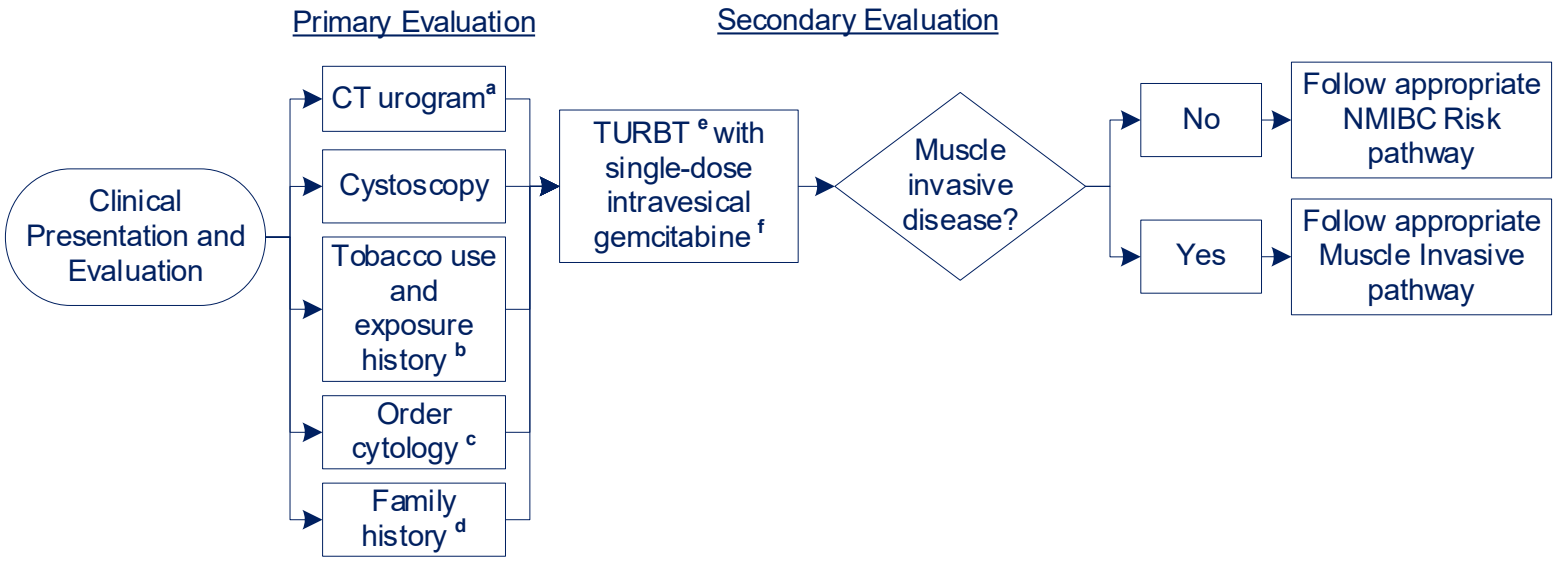
Bladder Cancer – Clinical Presentation and Evaluation



Clinical trial(s) always considered on pathway.

[a] In patients unable to receive IV contrast, order alternative upper tract imaging.

[b] **Exposure** Agent Orange, burn pits, and other occupational/environmental toxins.

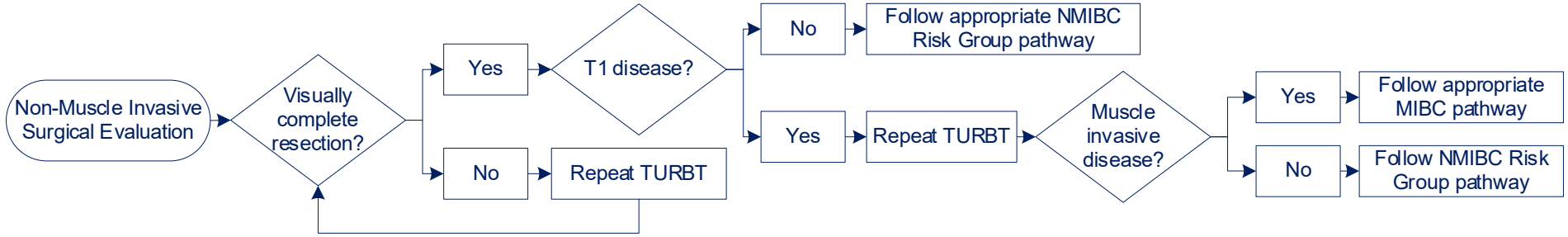
[c] **Cytology** order if results would change clinical management

[d] **Family History** family or personal malignancy history, suspicion for Lynch syndrome; age under 60 years

[e] **TURBT Transurethral Resection of Bladder Tumor (TURBT) with Exam Under Anesthesia (EUA)** and blue-light cystoscopy if clinically appropriate

[f] **Intravesical gemcitabine** for known or presumed low grade

Bladder Cancer – Non-Muscle Invasive Surgical Evaluation

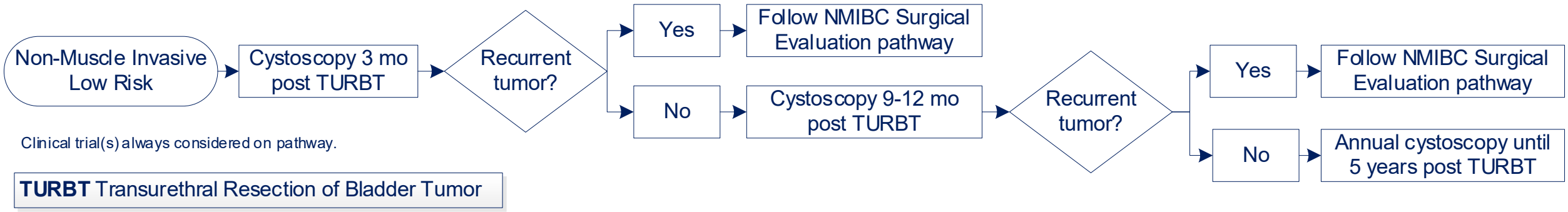


American Urological Association Non-Muscle Invasive Risk Stratification		
Low Risk	*Intermediate Risk*	*High Risk*
• Papillary urothelial neoplasm of low malignant potential *Or* • Low grade urothelial carcinoma ▪ Ta and ▪ ≤3 cm and ▪ Solitary	• Low grade urothelial carcinoma ▪ T1 or ▪ >3 cm or ▪ Multifocal or ▪ Recurrence within 1 year *Or* • High grade urothelial carcinoma ▪ Ta and ▪ <3 cm and ▪ Solitary	• High grade urothelial carcinoma ▪ CIS or ▪ T1 or ▪ >3 cm or ▪ Multifocal *Or* • Very high risk features (any) ▪ BCG unresponsive ▪ Variant histologies [a] ▪ Lymphovascular invasion ▪ Prostatic urethral involvement

[a] **Variant histologies** includes micropapillary, nested, plasmacytoid, neuroendrocrine, sarcomatoid, squamous or glandular predominant.

TURBT Transurethral Resection of Bladder Tumor

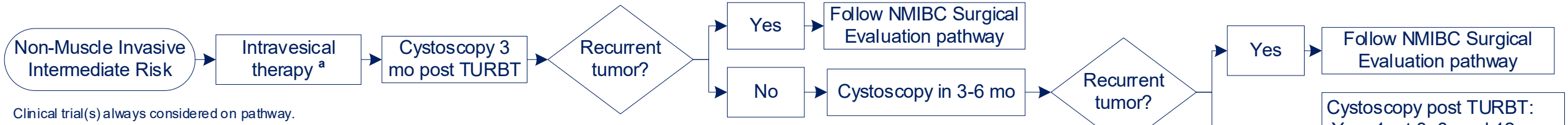
Bladder Cancer – Non-Muscle Invasive Low Risk



Clinical trial(s) always considered on pathway.

TURBT Transurethral Resection of Bladder Tumor

Bladder Cancer – Non-Muscle Invasive Intermediate Risk

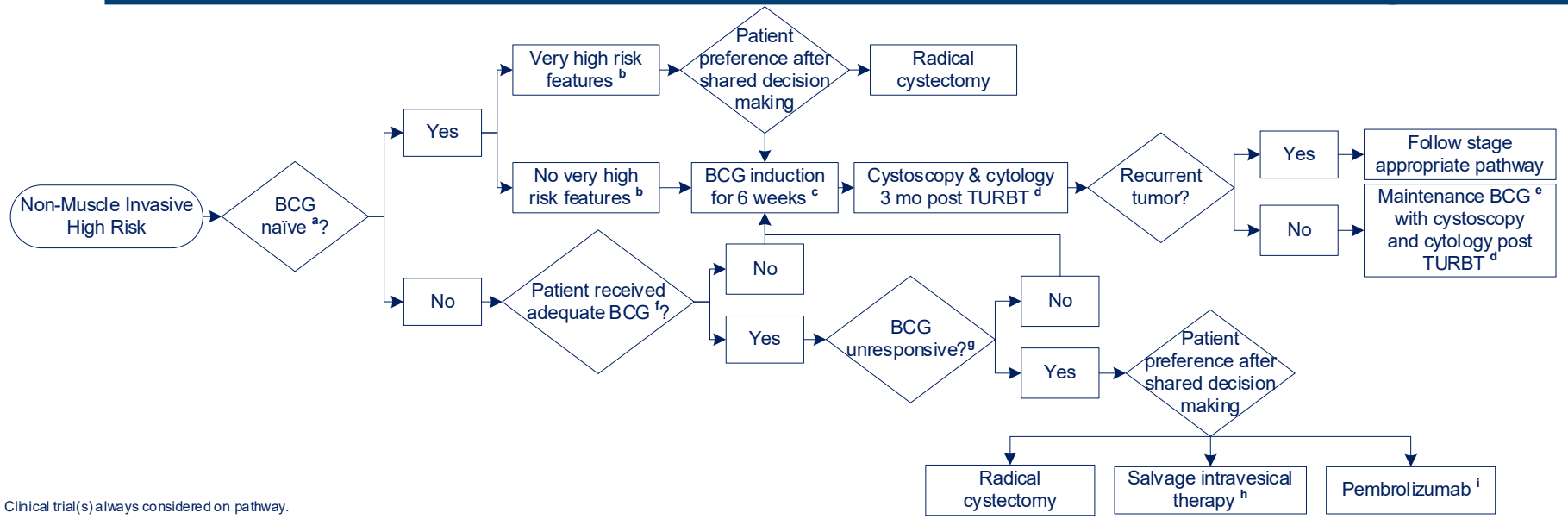


Clinical trial(s) always considered on pathway.

[a] **Intravesical therapy** BCG weekly instillations for 6 weeks preferred for high grade disease; if low grade or not available, gemcitabine once a week for six weeks within 3-4 weeks of TURBT; BCG or gemcitabine maintenance should be continued for one year

TURBT Transurethral Resection of Bladder Tumor

Bladder Cancer – Non-Muscle Invasive High Risk



Clinical trial(s) always considered on pathway.

[a] **BCG naïve** BCG non-exposed or greater than one year since last BCG

[b] **Very high risk features** include BCG unresponsive, variant histologies, lymphovascular invasion, or prostatic urethral invasion

[c] **BCG Induction** only one repeat induction BCG course

[d] **Cystoscopy and Cytology Post TURBT** surveillance schedule: years 1-2: every 3 months; years 3-4: every 6 months; years ≥5: annually

[e] **BCG maintenance** 3 week instillations at 3, 6, 12, 18, 24, 30, and 36 months (3 years) after start of induction BCG

[f] **Adequate BCG** ≥5 induction doses and ≥2 maintenance doses

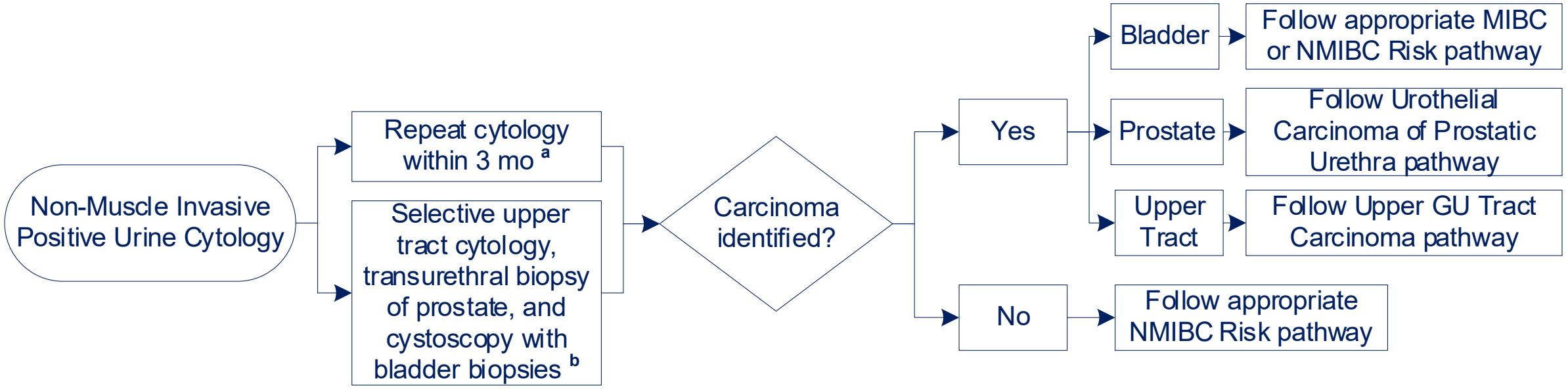
[g] **BCG unresponsive** Persistent high-grade disease or recurrence within 6 months of receiving at least 2 courses of intravesical BCG (at least 5 of 6 induction and at least 2 of 3 maintenance doses of BCG)

[h] **Salvage intravesical therapy** gemcitabine and docetaxel preferred

[i] **Pembrolizumab** indicated for treatment of patients with BCG-unresponsive, high-risk NMIBC with Tis tumors who are ineligible for or have elected not to undergo cystectomy

TURBT Transurethral Resection of Bladder Tumor

Bladder Cancer – Non-Muscle Invasive Positive Urine Cytology

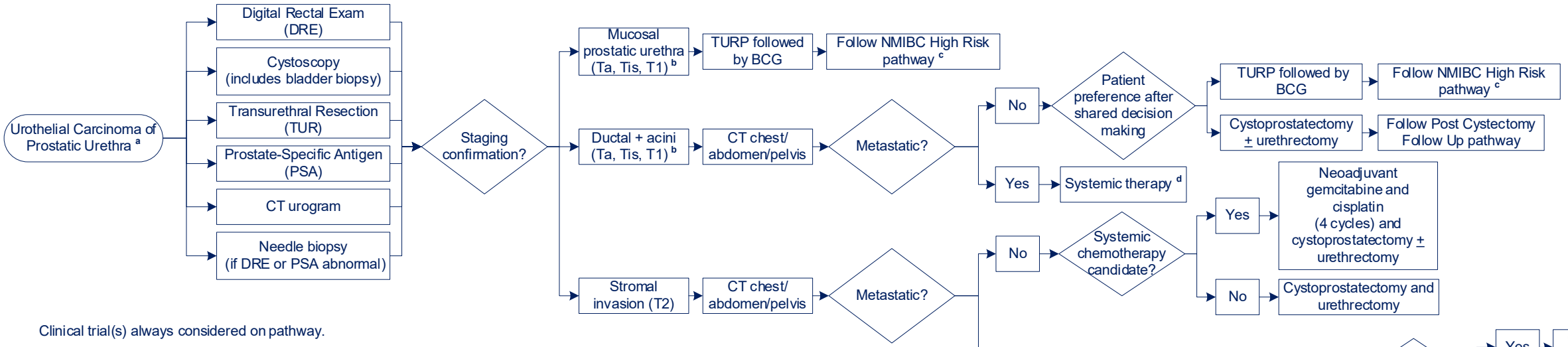


Clinical trial(s) always considered on pathway.

[a] **Cytology** Review clinical history with cytopathologist

[b] **Cystoscopy** Use enhanced technology if available

Bladder Cancer – Urothelial Carcinoma of Prostatic Urethra



Clinical trial(s) always considered on pathway.

[a] **Urothelial Carcinoma of Prostatic Urethra** solely isolated prostatic urethra involvement

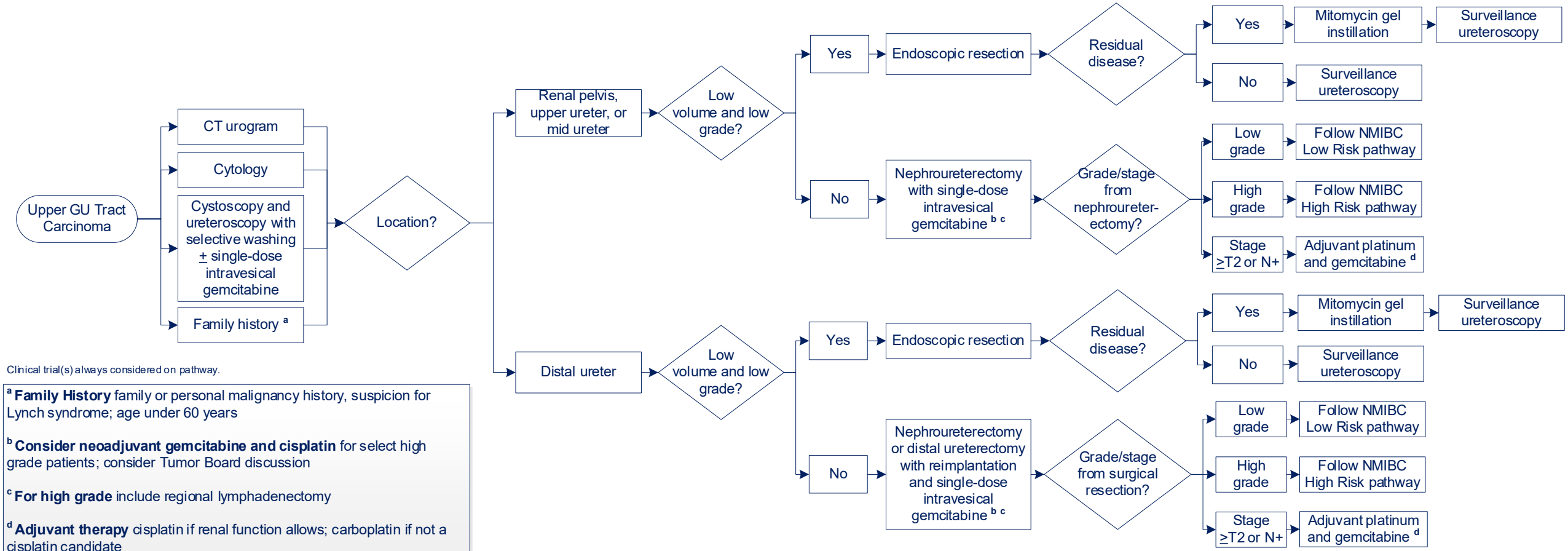
[b] **Ta, Tis, T1** based on TUR, confirm subepithelial involvement

[c] **Cystoscopy and Cytology Post TURBT** 6 months; surveillance schedule: years 1-2: every 3 months; years 3-4: every 6 months; years ≥5: annually

[d] **If cisplatin eligible**, prescribe gemcitabine and cisplatin followed by avelumab maintenance therapy; **if cisplatin ineligible**, prescribe gemcitabine and carboplatin followed by avelumab maintenance therapy

[e] **If only prior pelvic metastatic disease**, reimage with PET to ensure no metastatic disease prior to proceeding with surgery

Bladder Cancer – Upper GU Tract Carcinoma



Clinical trial(s) always considered on pathway.

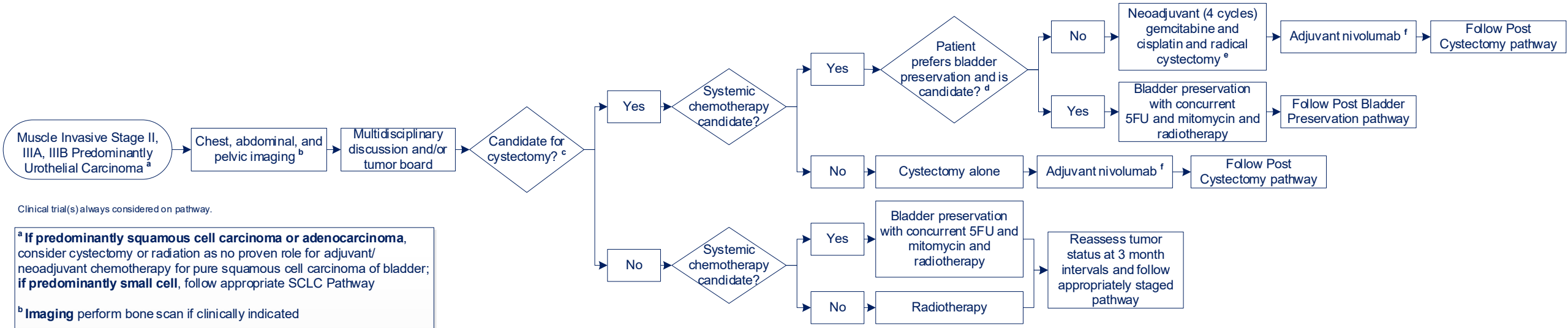
[a] **Family History** family or personal malignancy history, suspicion for Lynch syndrome; age under 60 years

[b] **Consider neoadjuvant gemcitabine and cisplatin** for select high grade patients; consider Tumor Board discussion

[c] **For high grade** include regional lymphadenectomy

[d] **Adjuvant therapy** cisplatin if renal function allows; carboplatin if not a cisplatin candidate

Bladder Cancer – Muscle Invasive Stage II, IIIA, IIIB Predominantly Urothelial Carcinoma



Clinical trial(s) always considered on pathway.

[a] **If predominantly squamous cell carcinoma or adenocarcinoma**, consider cystectomy or radiation as no proven role for adjuvant/ neoadjuvant chemotherapy for pure squamous cell carcinoma of bladder; **if predominantly small cell**, follow appropriate SCLC Pathway

[b] **Imaging** perform bone scan if clinically indicated

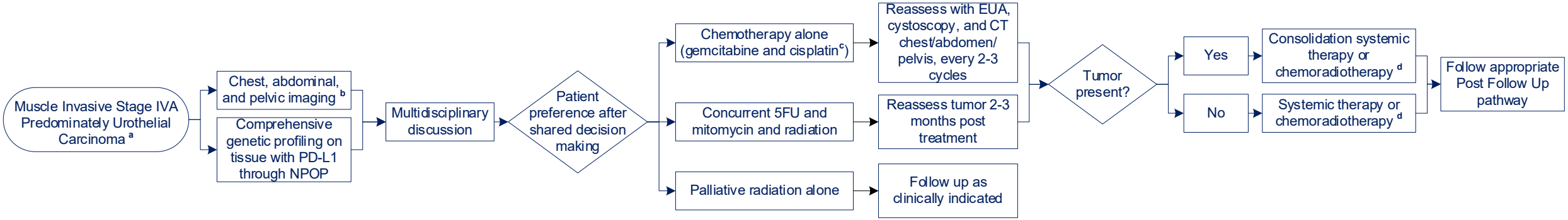
[c] **Patients with clinical node positive disease** should have resolution of adenopathy post chemo to become eligible for cystectomy

[d] **Candidate** Avoid bladder preservation in patients with hydronephrosis and extensive or multifocal carcinoma in situ

[e] **Consider Platinum-based chemotherapy** (4 cycles) if not given as neoadjuvant

[f] **Adjuvant nivolumab** for patients at high risk for recurrent MIBC following radical cystectomy with negative margins regardless of PD-L1 status

Bladder Cancer – Muscle Invasive Stage IVA Predominately Urothelial Carcinoma



Clinical trial(s) always considered on pathway.

[a] **If predominantly squamous cell carcinoma or adenocarcinoma**, consider cystectomy or radiation as no proven role for adjuvant/neoadjuvant chemotherapy for pure squamous cell carcinoma of bladder; **if predominantly small cell**, follow appropriate SCLC Pathway

[b] **Imaging** perform bone scan if clinically indicated

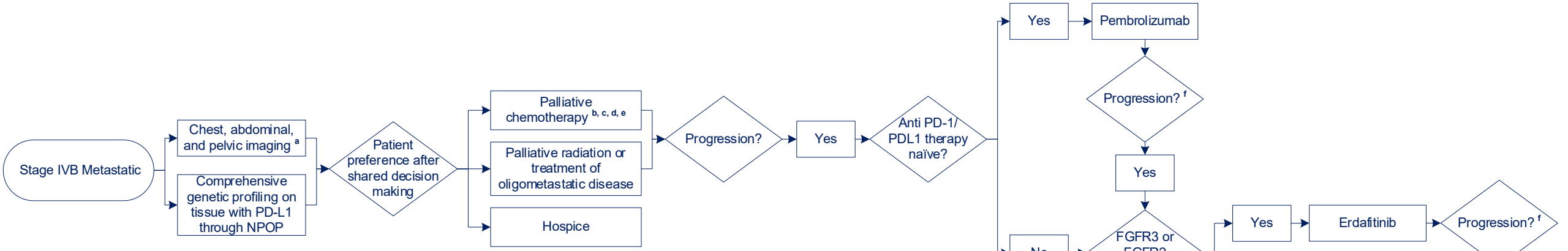
[c] **If patient not a cisplatin candidate,** recommend carboplatin

[d] **If no previous** radiation therapy and/or cystectomy

EUA Exam Under Anesthesia

NPOP National Precision Oncology Program

Bladder Cancer – Stage IVB Metastatic



Clinical trial(s) always considered on pathway.

[a] **Imaging** perform bone scan if clinically indicated, imaging of Central Nervous System (CNS) as clinically indicated

[b] **If cisplatin eligible**, prescribe gemcitabine and cisplatin followed by avelumab maintenance therapy; **if cisplatin ineligible**, prescribe gemcitabine and carboplatin followed by avelumab maintenance therapy

[c] If **patient progresses on initial platinum-based chemotherapy** prior to avelumab, recommend pembrolizumab

[d] If **not a platinum-based chemotherapy candidate**, recommend pembrolizumab

[e] **Consider** platinum-based chemotherapy if not previously given

[f] If **patient not a candidate for these therapies,** consider hospice and/or palliative radiation

NPOP National Precision Oncology Program

Criteria for Use

Erdafitinib: exclude patients with retinal/corneal abnormality at baseline or serum phosphate greater than upper limits of normal at baseline; perform ophthalmological exams at baseline and then monthly for the first 4 months of therapy, then every 3 months thereafter

Enfortumab Vedotin: exclude patients with preexisting neuropathy ≥ Grade 2, baseline ocular disorders, or uncontrolled diabetes at baseline

Bladder Cancer – Post Cystectomy Follow Up

Post Cystectomy Follow Up

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 5-10	Year >10
Imaging NMIBC	CT urogram at 3 &12 mo	Annual CT urogram				Annual renal ultrasound	As clinically indicated
Imaging MIBC	CT chest and CT urogram every 3-6 mo		Annual CT chest/abdomen/pelvis			Annual renal ultrasound	As clinically indicated
Blood Tests	CMP &CBC every 6 mo	Annual CMP and B_{12} levels				Annual B_{12} levels	
Urine Tests	Urine cytology every 6-12 mo; consider urethral wash every 6-12 mo	Urine cytology as clinically indicated Urethral wash cytology as clinically indicated					

Bladder Cancer – Muscle Invasive Post Bladder Preservation Follow Up

Muscle Invasive Post Bladder Preservation Follow Up

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 5-10	Year >10
Cystoscopy	Every 3 mo		Every 6 mo		Annually		As clinically indicated
Imaging	CT chest and CT urogram every 3-6 mo		Annual CT chest/abdomen/pelvis			As clinically indicated	
Blood Tests	CMP & CBC every 6 mo	Annual CMP					
Urine Tests	Urine cytology every 6-12 mo		Urine cytology as clinically indicated				

Questions?

Contact VHAOncologyPathways@va.gov